2022 HITA RESULTS & RENEWAL

Prepared for: Albert Lea ISD #241
April 13, 2022

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OVERVIEW

Current Plan Benefits

Incumbent Carrier Overview

Respondent Proposal: Blue Cross Blue Shield

Respondent Proposal: Medica

Respondent Proposal: PEIP

Respondent Proposal: UnitedHealth Care

OVERVIEW, cont.

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Renewal Models

Selection Criteria

Recommendation

RFP RESPONSES

The district received responses from:

- Blue Cross Blue Shield
- Medica
- PEIP
- UnitedHealth Care

The district received best and final responses from:

- Blue Cross Blue Shield
- Medica
- PEIP
- UnitedHealth Care

CURRENT PLAN BENEFITS

CURRENT PLAN BENEFITS

$1,200 Deductible Plan

	In-Network	Out-of-Network
Deductible Medical & Drug Combine	$1,200 Individual $2,400 Family	
Out-of-Pocket Maximum Medical & Drug Combine	$1,200 Individual $2,400 Family	$3,500 Individual $6,500 Family
Preventive Care	100% Coverage	100% Coverage
Office Visits	100% after Deductible	80% after Deductible
Hospital Visits	100% after Deductible	80% after Deductible
Prescription Coverage	100% after Deductible	80% after Deductible
Prescription Out-of-Pocket Maximum	Included Above	Included Above

CURRENT PLAN BENEFITS

$2,250 Deductible Plan

	In-Network	Out-of-Network
Deductible Medical & Drug	$2,250 Deductible Plan $4,500 Deductible Plan	
Out-of-Pocket Maximum Medical & Drug	$2,250 Individual $4,500 Family	$3,500 Individual $6,500 Family
Preventive Care	100% Coverage	100% Coverage
Office Visits	100% after Deductible	80% after Deductible
Hospital Visits	100% after Deductible	80% after Deductible
Prescription	100% after Deductible	80% after Deductible
Prescription Out-of-Pocket	Included Above	Included Above

CURRENT PLAN BENEFITS

$3,000 Deductible

	In-Network	Out-of-Network
Deductible Medical & Drug Combine	$3,000 Individual $6,000 Family	
Out-of-Pocket Maximum Medical & Drug Combine	$3,000 Individual $6,000 Family	$3,500 Individual $6,500 Family
Preventive Care	100% Coverage	100% Coverage
Office Visits	100% after Deductible	80% after Deductible
Hospital Visits	100% after Deductible	80% after Deductible
Prescription	100% after Deductible	80% after Deductible
Prescription Out-of -Pocket Maximum	Included Above	Included Above

CURRENT PLAN BENEFITS

$6,350 Deductible Plan

	In-Network	Out-of-Network
Deductible Medical & Drug	$6,350 Individual $12,700 Family	$10,000 Individual $20,000 Family
Out-of-Pocket Maximum Medical & Drug	$6,350 Individual $12,700 Family	$20,000 Individual $40,000 Family
Preventive Care	100% Coverage	100% Coverage
Office Visits	100% after Deductible	60% after Deductible
Hospital Visits	100% after Deductible	60% after Deductible
Prescription	100% after Deductible	60% after Deductible
Prescription Out-of-Pocket	Included Above	Included Above

INCUMBENT CARRIER OVERVIEW

RESPONDENT PROPOSAL: BLUE CROSS BLUE SHIELD

BLUE CROSS BLUE SHIELD

Financial Summary—Self-insured

Estimated maximum claim rate of: $7.5M

- Claim rates determine the aggregate protection of the plan
- Aggregate protection is the policy that protects the entire cost of the plan
- Claim amounts over the aggregate are covered by the insurance company

Administrative costs:

- **Per Contract Per Month (PCPM) : $11.74**
  - Does not include any taxes or assessments
  - Does not include ShareCare wellness program reimbursements

Specific stop-loss rate @ $125k

- Single: $102.70 ($91.70)
- Family: $256.86 ($229.34)
  - Specific stop-loss is the policy that protects expenses for individual high claimants

Maximum risk with taxes and fees—$8.4M

Blue Cross® and Blue Shield® of Minnesota

1 Out of 3 Americans Are Members of a Blue Cross and Blue Shield Network

The Aware network[1] provides your employees with easy access to a statewide network that includes more than 98% of hospitals and physicians in Minnesota — making it easy to get the care they need.

Cost-Cutting Convenience

Designed to make saving on healthcare as easy as possible, Blue Cross Aware Network offers a broad footprint of participating providers.

Blue Cross contracts with only the top-performing providers proven to deliver top-quality, effective care. Your employees may see significant savings and gain greater provider access.

A Perfect Match for Your Employees

The Aware Network[2]

- 176 Hospitals
- 17,968 Primary Care Providers
- 37,860 Specialty Care Providers

Available at Home and Abroad

With 95% of doctors and 96% of hospitals participating in the national BlueCard® PPO network across the country, your employees won't have any trouble finding care. On top of that, BlueCard® PPO network includes network-participating doctors throughout the world, giving your employees peace-of-mind as they travel.

Blue Cross® and Blue Shield® of Minnesota is a non-profit independent licensees of the Blue Cross and Blue Shield Association.

The Aware® Network from Blue Cross Gives Your Employees More Access and More Savings

Broad Access

- 107 million members nationally
- $382 million invested in health initiatives across the country[3]
- $1 billion invested in 140 companies and technologies working to improve our health care[4]

Superior Network Savings

- 3.7% average discount advantage[5]
- 55% average savings on in-network claims[6]

Global Availability

- 170 countries and territories contain network-participating providers

Unlock More Providers

- 96% of claims paid in-network[6]
- 98% of hospitals participate[7]
- 95% of doctors participate[7]

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

1 This network includes providers one county in to the neighboring states of Iowa, South Dakota, North Dakota, and Wisconsin. When seeking care in these counties, employees should search for providers using Aware Network (not BlueCard PPO).

2 Numbers are reflective of signed contracts as of March 2018 and are subject to change.

3 Blue Cross Blue Shield Community Investment Report, 2018.

4 Blue Cross Blue Shield Association Data, 2018.

5 National Discount Benchmarking Study, CY 2015.

6 ValueQuest Cost Model at a Glance, MY 2016.

7 Consortium Health Plans Network Compare Findings, Q3 2017.

Provider Discounts

The Aware PPO Network from Blue Cross Provides Impressive Discounts to Your Employees

Average Discounts: Aware Network (01/2019)			
Area	Inpatient Hospital	Outpatient Hospital	Physician
Minnesota Metro	41.2%	45.0%	31.7%
Minnesota Non-Metro	31.1%	34.1%	29.8%
Statewide	37.7%	40.5%	31.1%

Blue Cross only partners with healthcare providers proven to offer the highest quality and value of care to improve the health of your employees and lower costs. Value-based pricing does not apply to all providers in the Aware network, need to reword.

Blue Cross sends this data back to the stakeholders of self-funded health benefit plans to help them assess the usage of their plans among network-participating providers.

Out-of-Network Provider Negotiations

There are some cases in which a participant must use a non-contracted provider or a provider located outside of Minnesota. When this occurs, Blue Cross utilizes a shared savings arrangement with MultiPlan, a third-party vendor, to evaluate and financially negotiate these claims. MultiPlan also analyzes claims for waste and abuse (e.g., seemingly unrelated services, excessive services reported, and unlikely combinations of services performed), and addresses these claims through clinical negotiation. With both negotiation products, the member is not held liable for the difference between the billed charges and the negotiated rate (known as balance billing).

In the cases where MultiPlan negotiations for Blue Cross claims are not successful, Blue Cross pays at the MultiPlan Data iSight rates.

Blue Cross Customer Service

Better Service. More Satisfied Customers

Through the Aware Network from Blue Cross and Blue Shield of Minnesota, your plan members gain toll-free telephone access to U.S.-based Customer Service Representatives from 7:00 a.m. to 8:00 p.m. Central time, Monday through Friday. More services are available outside of normal business hours, such as Blue Cross interactive voice response service or online resources.

These tools can help employees:

- Find answers to health plan questions
- Find doctors and hospitals
- Email a Customer Service Representative
- Schedule a Doctor On Demand Appointment

Live Phone Support, Monday-Friday from 7:00 a.m. to 8:00 p.m. CT

Secure Online Member Portal, Available 24 Hours

Interactive Voice Response by Phone, Available 24 Hours

Blue Cross Member Service Touchpoints			
Customer Service Representatives	Online Resources	Nurse Guides	Case Managers
• Assist employees with health coverage questions • Utilizes in-house experts for clinical support • Help finding network-participating providers • Inform employees of available services	• 24/7 Access to "Find a Doctor" web-based tool • Claims and medical spending account questions • Cost/quality comparisons on providers • Doctor On Demand— live appointments via video on the web	• Provide assistance in navigating the health care system • Offer clinical guidance • Assist employees in determining which services they need • Transfer to case managers, if needed	• Assess member needs • Provide emotional support and education • Outline coordination of benefits for employees • Resolve gaps in care • Provide connection to health specialists
Self-Directed Support			Active Outreach

BLUE CROSS BLUE SHIELD

Extras

Sharecare: New health and well-being platform

Together, Blue Cross and Blue Shield of Minnesota and Sharecare are transforming how Blue Cross members view their health. Members begin their health care journey online by completing the RealAge® test. RealAge reveals a person's age based on health, genetics, and lifestyle habits versus their chronological age. Rather than a numerical well-being score, RealAge provides a simple and intuitive understanding of their health.

Virtual health and wellness support tools

From lowering stress to managing weight or a chronic condition, BCBS offers the virtual support your employees need. Their engaging health and wellness programs not only help prevent disease and injury today but reduce the likelihood of employees becoming ill or impaired tomorrow.

BLUE CROSS BLUE SHIELD

Plan Deviations —

No deviations

RESPONDENT PROPOSAL: PEIP

PEIP

Financial Summary

- Insured response would be no increase for July, 2022
- Revenue from premium for 2021/2022 is $8.6M
- Proposed revenue in 2022/2023 to $8.6M
- Response does not include a second year rate cap but does require two year commitment

PEIP does not adhere to bid protocols or future “HITA” mandates

PEIP

Carrier Overview

- Created in 1989 by state statute (Minn.Stat. 43A.316).
- PEIP is administered by the Department of Minnesota Management and Budget (state of Minnesota), and is committed to delivering insurance options to public employees.
- Goal of PEIP – to bring affordable and sustainable health insurance options to public employers leveraging off of the bargaining ability of 30,000+ PEIP members.
- PEIP is a self-insured pool.
- PEIP requires a two-year commitment.
- PEIP does not offer a second-year rate guarantee.
- PEIP is a variant plan design structure.
    - Four levels of benefit coverage within each plan.
    - Coverage level is determined by the member's primary care clinic designation.
    - Specialist visits require referrals from the designated primary care clinic.
- Reserves (excess funds earned in premium) are shared with the other entities within PEIP.
- Reserves are controlled by PEIP.
- Benefits are negotiated and determined by the state, not the district employees or PEIP.
- PEIP Plans present a considerable cost shift to covered members with benefit reductions, without the requisite savings in premiums.

PEIP

Network Overview

As a self-funded pool, PEIP offers three network administrators:

- Blue Cross Blue Shield of MN
- PreferredOne
- HealthPartners

PEIP offers three different plan designs:

- Advantage Plan
- Value Plan
- HSA Qualified Plan

Each PEIP plan design contains four levels of benefits. Benefits are determined by which primary care clinic a member has designated.

PEIP is administered by Innovo Benefits Administration by contract with the State of MN.

- PEIP does not provide anything other than ledger claim data.
- PEIP is the least transparent insurer in Minnesota
- PEIP is allowed the largest margin of any insurance offering in Minnesota.

PEIP

Plan Deviations

- PEIP plans do not match current benefits
- PEIP plans are based off of primary care clinic model
- PEIP does not provide out-of-network benefits
- PEIP did comply with the District's RFP
- PEIP maintains the ability to change benefits without negotiation
- PEIP does not provide transparent claim/underwriting data

RESPONDENT PROPOSAL: MEDICA

Medica

Carrier Overview

Medica is a non-profit health plan that serves communities in Minnesota, Iowa, Kansas, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota and Wisconsin — the heart of America. As a company, we empower communities by listening to their voices, learning about community needs, and devoting time and resources to help.

Medica partners with the communities it serves in many ways, including the Medica Foundation, a nonprofit, charitable grant-making foundation. The Medica Foundation, which provides more than $1 million in grants annually, generally seeks to fund community-based programs and initiatives that can provide sustainable, measurable improvements in the availability, access and quality of health care.

Values include:

- Customer Focus
- Excellence
- Stewardship
- Integrity
- Diversity

Medica was founded by physicians in 1975 as Physicians Health Plan. It was the first open-access health plan in the state. In 1991, PHP merged with Share to become Medica. And in 1994, Medica merged with HealthSpan to form Allina Health System, an integrated organization offering both health care coverage and medical services. Medica became an independent health plan in 2001.

Medica

Network Overview

Providing Exceptional Choice, Access, and Coverage

Our network options provide coverage for your employees whenever and wherever they need it. We propose two options for your consideration.

Medica Choice® Passport

Medica Choice Passport is our broadest network, featuring access to more than 960,000 doctors, 5,900 hospitals, and 73,000 ancillary providers across the country. This national network has a single call center, and we'll pass on 100 percent of the negotiated network savings to Albert Lea Schools.

Accountable Care Organizations

ACOs offer networks or teams of health care providers (e.g., clinics, hospitals, doctors, and specialists) that collaborate with Medica to make health care more efficient and improve the member experience. ACO networks are smaller than our other open-access networks, but their benefits are significant. We've found that, compared to open-access networks, ACOs improve care and cost in distinct, measurable ways, including cost savings, fewer hospital readmissions, fewer emergency room admittances, increased preventive care utilization, higher generic medication utilization, and improved adherence to antidepressant medicine.

We're pleased to offer you access to the following Medica ACOs, which we expect to save you 7–12 percent compared to our open-access plan:

- **Park Nicollet First** builds on the strength of one of the nation's largest multi-specialty clinics, providing members with access to over 20 neighborhood clinics and more than 55 medical specialties.
- **Ridgeview Community Network®** provides local, personalized care at one of the few independent health care systems in Minnesota.
- **VantagePlus with Medica** includes 3,500 primary and specialty care physicians, 650 clinics, and 12 hospitals with providers members know and trust from M Health Fairview, North Memorial Health, and many popular independent clinics.

Virtual Care

Accessible via website and a mobile application, **Amwell** is available 24/7 and can treat more than 100 common medical conditions. Amwell also offers behavioral health care services, including therapy and psychiatry. The cost per visit varies by service type, and eligible services are covered under your plan as a behavioral health office visit. Members can select the doctor who works best for them. Before starting a visit, Amwell shows the participant a list of available doctors and their experience and ratings. If a prescription is needed, Amwell sends it to the individual's pharmacy of choice, and the cost is based on the member's plan coverage.

Medica

Carrier Overview — Customer Transition

Delivering Value through the Power of Partnerships

A Proven Transition Plan

For some organizations, transitioning from one health plan to another is a significant step. Medica has expertise in the art of these transitions. Our well-established installation process helps to ensure that you and your employees experience a smooth move to Medica. We'll complement existing health and wellness programs with new solutions that personalize the experience, encourage employee engagement, and provide exceptional customer service.

The designated account management team assigned to Albert Lea Schools will be responsible for the management, service coordination, benefit and pricing consultation, and implementation of your account. Your team will also respond to service and informational requests and collaborate with the school district on annual open enrollment planning, health fairs, and wellness promotions.

Medica account managers and account executives serve as liaisons between our customers and Medica operations to ensure that issues are identified, prioritized, and resolved. The team will also proactively educate customers on administrative procedures, policies, and developments within Medica and the health care industry.

We offer an organization-wide commitment to supporting Albert Lea Schools and your employees. Your account management team will work with you to plan for open enrollment and will continue to support you throughout the plan year. Your Medica team will do the following:

- Update you on changes to our products, operations, and systems and their potential impact.
- Evaluate continuously your needs and recommend Medica benefit plans and programs as appropriate.
- Coordinate delivery of the overall service experience.
- Oversee activities of service representatives, assisting with escalated issues as needed.
- Work closely with you and your benefits consultant during the annual renewal process.

Continuous Improvement

Achieving customer and member satisfaction is a priority for Medica. We want to do more than offer high-quality care and cost savings. We strive to provide great customer service. To that end, we survey clients and members about our work as part of our process of continuous improvement. In 2019, overall satisfaction with Medica increased for the third year in a row, with our Net Promoter Score® (NPS) jumping from 39 to 48 from 2018 to 2019. One respondent noted, “Quick response time, good coverage, great network, competitive pricing.”

Medica Program Information

My Health Rewards by Medica®

Customizable and comprehensive, My Health Rewards features unique digital lifestyle and condition management coaching modules, health assessments, activity tracking, and more. Members can establish and maintain healthy goals and habits using market‑leading technologyand support tools. Its suite of programs inspires sustainable behavior change. **My Health Rewards is included in your plan, and participants 18 years and older are eligible for $160 in rewards incentives annually from Medica.**

Healthy Savings

Healthy Savings is about making eating healthy easier and more affordable. The program provides members discounts at several chains on the healthiest foods in five categories. Members can locate participating stores, view weekly promotions, track their accumulated savings, and more through the Healthy Savings website and app. **Medica Healthy Savings is included in your plan, and participants can save up to $250 a month on healthy food.** You can supplement Healthy Savings with a fresh produce program your employees can use to purchasefresh fruits and vegetables.

Sanvello™

Finding ways to cope with stress is essential to maintaining—even improving—health and well‑being. Sanvello can help. This top‑rated self‑help app empowers individuals to engage with activities to improve their mental health anytime, anywhere. Members can stay engaged each day for benefits they can feel. **Sanvello is available to members 13 years and older.**

Ovia Health™

Ovia Health is a trio of smartphone apps that provides personalized guidance, support, and coaching across the reproductive health and parenting spectrum, from fertility health tracking to getting pregnant to navigating pregnancy, postpartum, and parental wellness. Individuals can useany or all of the apps Ovia Health offers, and members receive exclusive access to enhanced features not available to all app users. **Ovia Health is included in your plan.**

Fit Choices℠ by Medica

Each month, members can earn up to a $20 credit when they meet their visit requirement at aparticipating health club. Members simply show their Medica ID card and work out. The club tracks visits and notifies Medica. The Fit Choices network has more than 8,000 locations (see **medica.com** for the list). Participating is easy. The payback is great: Get fit, reduce stress, and save money. **Fit Choices is included in your plan with a visit requirement of eight visits per month.**

Omada

Omada for Prevention is a digital lifestyle change program that helps at‑risk employees loseweight and reduce their risk for diabetes and heart disease. *Omada for Diabetes* provides personalized support and digital tools to help employees with diabetes meet their goals.

Omada is included in your plan.

Medica

MEDICA®

Extras — Health and Wellbeing

Innovating for Your Evolving Health and Well-Being Strategy

We have several innovative programs that help members become healthier. My Health Rewards by Medica®, Medica Healthy Savings, and Ovia HealthTM are included at no additional cost.

My Health Rewards by Medica

My Health Rewards is a customizable, comprehensive wellness experience featuring unique digital lifestyle and condition management coaching modules, health assessments, activity tracking, and more. Our suite of programs inspires sustainable behavior change. The idea behind My Health Rewards is simple: Learn. Do. Become. **The program is included in your premiums, and participants 18 years and older are eligible for $100 in rewards incentives from Medica**.

The technology behind My Health Rewards leverages years of research on how to motivate individuals to take a more active role in their health care. Through market-leading technology and support tools, members can establish and maintain healthy goals and habits. Our suite of programs offers a unique level of personalization, socialization, interaction, and engagement that inspires sustainable behavior change:

- **Daily Learning Cards:** These daily “learn and explore” cards in all well-being categories create a mindset of success, control, and momentum. Members may choose the topics they wish to see.
- **Health Assessment:** Although brief, it’s comprehensive, evaluating participants’ evolving status in areas such as sleep, fitness activity, and quality of life as well as disease- and condition-specific risks, such as heart health, cholesterol, diabetes, pain, and many others.
- **Journeys:** Members choose from a variety of health topics, which include lifestyle change, financial fitness, sleep and stress, weight management and physical activity, nutrition, and tobacco cessation. Some, such as asthma and diabetes, are about specific conditions.
- **Nutrition Guide:** This nutrition plan is personalized for each member. Tracking tools, nutrition resources and tips, reminders, and rewards provide practical guidance and a framework for adopting healthy eating habits.
- **Sleep Guide:** This sleep plan is tailored to the member’s sleep goals. Sleep-tracking tools, resources, tips, reminders, and rewards offer practical guidance and a framework for adopting healthy sleep habits (e.g., pre-bedtime routines, sleep environment, and quieting the mind).

with a corresponding reward amount. Points accrue for healthy behavior and activities, such as getting the recommended amount of sleep each night and tracking sleep on a regular basis, daily calorie tracking, and many more.

Medica

Financial Summary—Self-insured

Estimated maximum claim rate of: $7.44M

- Claim rates determine the aggregate protection of the plan
- Aggregate protection is the policy that protects the entire cost of the plan
- Claim amounts over the aggregate are covered by the insurance company

Administrative costs:

- **Per Contract Per Month (PCPM) : $9.39**
    - Does not include any taxes or assessments

Specific stop-loss rate @ $125k

- Single: $97.46 ($91.70)
- Family: $243.73 ($229.34)
    - Specific stop-loss is the policy that protects expenses for individual high claimants

Maximum risk with taxes and fees—$8.3M

MEDICA®

Medica

Specialty Pharmacy

According to ESI, in 2020, specialty drugs accounted for more than half of total drug spending in the United States. **Accredo Specialty Pharmacy** is our partner in helping us manage the needs of members with chronic and complex medical conditions. Accredo also provides pharmaceutical consultation to physicians treating these patients. Together, Medica and Accredo have deployed successful strategies that ensure the most appropriate use of these high-cost drugs.

Medica has also developed a strong partnership with **Magellan Health** to manage pharmacy expenses across medical benefits. With guidance from experts in common and complex diseases, we've achieved administrative efficiencies in our process and increased provider and member satisfaction rates, positively affecting the lives of patients struggling with complex medical conditions.

Caring for Members' Health and Wellness

Our range of health and wellness solutions combines programs that promote better health, tools that provide 24/7 support, and opportunities to earn or save money while developing healthy habits.

My Health Rewards by Medica®

This program motivates members to reach their wellness goals. My Health Rewards features a health assessment, unique digital lifestyle and condition management

coaching modules, activity tracking, and more. The program encourages daily engagement, and members can earn rewards by tracking healthy habits and accessing other features. A mobile app makes participating easy. *My Health Rewards is included in your plan, and members 18 years and older are eligible for $220 in rewards incentives annually from Medica.*

Eat Fit Go

Members can order healthy, ready-to-eat meals and have them delivered to a home or office. Made with high-quality, allergy-friendly ingredients, the meals stay fresh for at least 10 days in the refrigerator. *Eat Fit Go is included in your*

RESPONDENT PROPOSAL: UNITEDHEALTHCARE

UNITEDHEALTHCARE

Financial Summary—Self-insured

Estimated maximum claim rate of: $7.5M

- Claim rates determine the aggregate protection of the plan
- Aggregate protection is the policy that protects the entire cost of the plan
- Claim amounts over the aggregate are covered by the insurance company

Administrative costs:

- **Per Contract Per Month (PCPM) : $3.83**
    - Does not include any taxes or assessments
    - 24 month rate

Specific stop-loss rate @ $125k

- Single: $112.71 ($91.70)
- Family: $309.96 ($229.34)
    - Specific stop-loss is the policy that protects expenses for individual high claimants

Maximum risk with taxes and fees—$8.5M

UNITEDHEALTHCARE

Network Overview

The Choice Plus Plan highlights

Get a plan with access to a national network and the choice of out-of-network coverage.

- Save money by staying in our network. A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in our network.
- There's coverage if you need to go out of the network. You can receive care and services from anyone in or out of our network. Out-of-network means that a provider does not have a contract with us. It's important to remember, out-of-network providers will likely charge you more than network providers.
- There's no need to select a primary care physician (PCP) or get referrals to see a specialist. Consider choosing a PCP. Your PCP can be your partner in managing your care. They can help you avoid duplicating tests and services and connect you to a specialist.

Preventive care is covered 100 percent in our network.

Look for care in our network first.

The doctors and facilities in our network have agreed to provide you services at a discount. We have:

- 895,000+ physicians and health care professionals

5,600+ hospitals

How paying for network care works

- You pay a copayment for doctor visits and prescriptions.
- You pay a deductible before your plan will pay for covered services.
- You pay coinsurance, where you share a percentage of the cost with your plan.

You are protected with an out-of-pocket limit. You'll never pay more than your out-of-pocket limit during the plan year. The out-of-pocket limit includes all of your network payments.

UNITEDHEALTHCARE

Carrier Overview

- UnitedHealthcare (UHC) is based in Minnetonka, Minnesota.
- UHC began offering insured and administrative solutions in Minnesota in 2018.
- UHC purchased PreferredOne in 2021
- UHC provides the most transparent and accessible claims data of any carrier.
- UHC struggles with coverage language other Minnesota carriers utilize to determine coverage.
    - MN carrier's coverage criteria is based from the State of MN HMO guidelines
- UnitedHealthcare, a part of UnitedHealth Group, is a for-profit managed health care company.

UNITEDHEALTHCARE

Advocate4Me

A single point of contact

Whether employees contact us or we proactively reach out to them, they'll be guided by the Elite expert best suited to their needs. That same Advocate will be their champion who:

- Serves as their single point of contact, sticking with them until their inquiry is resolved
- Makes it easier for them to get back in touch by providing a direct number and email address

An integrated, personal experience

Our entire care team uses personalized data and insights to create an individualized experience for each employee. So whether speaking to an Advocate, nurse or coach, employees have the support they need to help them make more informed health care choices.

Real-time collaboration with a virtually connected care team

The Elite care team, which includes Advocates and dedicated nurses, collaborates across clinical, behavioral, pharmacy, claims and benefit needs. They're always in conversation with each other, looking for ways to create or improve the employee health journey. Because we deliver our own benefits, claims, programs and pharmacy, Advocates are able to manage it all in real time.

UNITEDHEALTHCARE

Network Overview

The Choice Plus Plan highlights

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The doctors and facilities in our network have agreed to provide you services at a discount. We have:

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How paying for network care works

- You pay a copayment for doctor visits and prescriptions.
- You pay a deductible before your plan will pay for covered services.
- You pay coinsurance, where you share a percentage of the cost with your plan.

You are protected with an out-of-pocket limit. You'll never pay more than your out-of-pocket limit during the plan year. The out-of-pocket limit includes all of your network payments.

UNITEDHEALTHCARE

Extras

- Includes Personal Health Support our engagement solution to providing employees the support they need to navigate through any healthcare needs.
- Includes annual **$10,000** wellness credit
- Includes **$100,00** Discretionary credit
- love hearing our story on OptumRx integration and how that sets us apart from our competitors.
- We have an amazing relationships with all the local districts we have written over the past few years and our local Account Management team continues to deepen those relationships.
- Performance Guarantee included for operations, implementation, customer service etc.

RATE ANALYSIS

CURRENT RATES

$1,200 Deductible Plan	2021/22
Single	$1,134
Family	$2,845
$2,250 Deductible Plan	
Single	$994
Family	$2,494
$3,000 Deductible Plan	
Single	$913
Family	$2,290
$6,350 Deductible Plan	
Single	$638
Family	$1,592

Fixed Costs Comparison

BCBS Self Funded Proposal		BCBS Self Funded Proposal	
Expected Claims (current enrollment)		Expected Claims (current enrollment)	
Total	$6.530,660	Total	$6.530,660
Maximum Claims (current enrollment)		Maximum Claims (current enrollment)	
Total	$7,510,259	Total	$7,510,259
Administration without Rebates		Administration without Rebates	
Per Contract	$11.51	Per Contract	$11.74
Stop-loss*—Specific @ $125,000		Stop-loss*—Specific @ $125,000	
Single	$91.70	Single	$102.70
Family	$229.34	Family	$256.86
Total (with taxes and fees*)		Total (with taxes and fees*)	
Single	$129	Single	$139
Family	$267	Family	$277
Total Fixed	$966k	Total Fixed	$975k

INSURED CARRIER: CURRENT RATES VS. PEIP RATES

BCBC Rates 2021/2022	
$1,200 Deductible Plan	Current
Single	$1,134
Family	$2,845
$2,250 Deductible Plan	
Single	$994
Family	$2,494
$3,000 Deductible Plan	
Single	$913
Family	$2,290
$6,350 Deductible Plan	
Single	$638
Family	$1,592

PEIP Rates 2022/2023	
Advantage Value	Proposed
Single	$1,094.68
Family	$2,922.76
Advantage High Plan	
Single	$1,220.60
Family	$3,259.00
Advantage HSA Plan	
Single	$852.24
Family	$2,274.48

Notable Comparisons

- 1 year rate guarantee

RENEWAL DISPLAY

Renewal Incurred Claims

Month & Year	Claims		Members
	Monthly	YTD	
Mar-20	$0	$0	0
Apr-20	$0	$0	0
May-20	$0	$0	0
Jun-20	$0	$0	0
Jul-20	$202,918	$202,918	0
Aug-20	$318,553	$521,471	942
Sep-20	$292,052	$813,523	968
Oct-20	$437,743	$1,251,266	923
Nov-20	$407,598	$1,658,864	923
Dec-20	$411,239	$2,070,103	924
Jan-21	$626,722	$2,696,825	926
Feb-21	$810,709	$3,507,534	910
Total	**$3,507,534**		**6,516**

Month & Year	Claims		Members
	Monthly	YTD	
Mar-21	$518,218	$518,218	911
Apr-21	$651,733	$1,169,951	909
May-21	$586,816	$1,756,767	906
Jun-21	$758,176	$2,514,943	903
Jul-21	$463,831	$2,978,774	905
Aug-21	$269,326	$3,248,100	902
Sep-21	$361,287	$3,609,387	917
Oct-21	$672,129	$4,281,516	885
Nov-21	$767,218	$5,048,735	878
Dec-21	$834,416	$5,883,151	883
Jan-22	$650,476	$6,533,627	881
Feb-22	$413,198	$6,946,825	871
Total	**$6,946,825**		**10,751**

2022 Pre-Renewal Position

	Period 1		Period 2
Claims	$6,946,825		$3,507,534
Claim Capture	$0		$0
Claims Applied	$6,946,825		$3,507,534
Trend	13.13%		19.53%
Trended Claims	$7,858,596		$4,192,380
Renewal Claims	$7,858,596		$4,192,380
Member Months	10,751		6,516
PMPM	$730.96		$643.40
Weight	70%		30%
Weighted Claims	$511.67		$193.02
Manual Factor		1.05	
Manual Factor	$534.70		$201.71
Cumulative Total		$736.41	
Current Members		871	
Experience Projection per month		$641,409.17	
Experience Projection Annually (EPA)		$7,696,910.06	

Projected Annual Claims	$7,696,910.06	
Fixed Charges (PMPM)	$90.69	
Annual Fixed Charges	$975,000	
Current Income (From Enrollment)	$8,665,199	
Total Calculated Need	$8,671,910.06	0.08%
	Increase $6,711	

SELECTION CRITERIA

SELECTION CRITERIA

Evaluation Criteria

Evaluation of proposals will take into account (but is not limited to) the following criteria:

Compliance with specifications

Contract provisions

Provider network and Provider Contracts

Premium rates and guarantee periods

Proposer's ability to adequately service the District's employees and their dependents
Ease, cost and effectiveness of transition from present carrier

The District reserves the right to accept or reject any or all proposals, to waive informalities in the proposals and to negotiate with carriers on benefits, premiums and other contract terms (as allowed under Section 471.6161 of Minnesota Statues).

RECOMMENDATION

Given the third party administrative responses from the market and our NIS analysis, it is our recommendation to remain with the incumbent and accept the BCBS proposal as presented.

The District received three competitive proposals for plan administration and one competitive proposal from PEIP. While each of the proposals were unique in their response, all four were close on pricing and network availability. The PEIP proposal if accepted would require the district to transition away from our current self-insured environment.

BCBS, Medica and UnitedHealthcare all offered similar aggregate stop loss protection. The total plan risk differential was +/- $100,000 with Medica coming in at $8.3M, BCBS at $8.4M, and UnitedHealthCare at $8.5M.

Given the quality of all the proposals and the similarity in plan projections and risk, the NIS recommendation is to remain with BCBS which provides the least disruption to members likely the most competitive provider discount.

SELF-FUNDING INFORMATION

ADVANTAGES OF SELF-INSURANCE

- One of the biggest advantages of a self-funded health insurance plan is that it can have a positive impact on the organization's cash flow.
    - Self-funded plans are also generally exempt from premium taxes in most states, lowering employer costs in that area dramatically.
- The money collected by the organization is only paid out when claims actually occur and can stay in a reserve account accruing interest until it is needed.
    - In addition, if claims during a particular month are lower than anticipated, that money adds to the reserve and earns additional interest, creating a long-term financial benefit.
- An overall improvement in employee health can lead to an immediate reduction in claims, which means a lower spend and feeds back into the organization's reserve fund.
    - If those trends continue, there may be a reduction in the necessary contributions made by both employers and workers.
- As another advantage, organizations may be able to customize self-funded plans to a degree. While collective bargaining agreements may require certain benefits be covered by any employer-sponsored plan, self-funding may allow for some flexibility. This flexibility can also be advantageous in the event an employer's healthcare requirements or needs change.
- In addition, since a specialized third-party provider completes much of the administration of the plan, employers can refocus their internal resources on other relevant issues.

DISADVANTAGES OF SELF-INSURANCE

- Stop-loss insurance
    - Stop-loss insurance (also knows as excess insurance) is a product that provides protection against catastrophic or unpredictable losses. Under a stop-loss policy, the insurance company becomes liable for losses that exceed certain limits called deductibles.
    - There are two common types of stop-loss insurance.
        - Aggregate Reinsurance and Specific Stop-Loss Insurance.
- The assumption of greater risk.
    - Large, unexpected medical claims require that the district has the financial resources to meet its claims obligations.
- Unpredictability puts greater demands on budgeting and cash flow.
    - Budgeting is more difficult because health care expenses will vary from year to year.

SELF-INSURED TERMS

- Aggregate reinsurance
    - A policy that is activated when the district's total claim payments exceed the stipulated amount.
    - Aggregate policies are required by the state of Minnesota.
- Specific stop-loss insurance
    - A form of excess risk coverage that provides protection for the employer against a high claim on any one individual.
        - Specific stop-loss is protection against a single claimant rather than abnormal frequency of claims in total.